

Well-Child Care Claim Form

Family Assistance C.A.R.E. Coordinator: (Tel.) 1-800-462-1120

Parent/Guardian Name: _____ Parent/Guardian SSN: _____

Health Insurance Company: _____

Remember: You do not need to pay this bill. MassHealth can pay your doctor directly.

Fill out one section below for each copay, deductible, or coinsurance amount. Attach a copy of the bill, or if you paid the amount, a copy of the receipt showing how much you paid.

Name of Child	Child's SSN	Date of Visit
Type of Visit (check <input checked="" type="checkbox"/> one) <input type="checkbox"/> Physical Exam <input type="checkbox"/> Immunization <input type="checkbox"/> Lab Test <input type="checkbox"/> Hearing Test <input type="checkbox"/> Vision Test	Did you pay this bill? <input type="checkbox"/> Yes <input type="checkbox"/> No	Amount
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When you have completed this form, send the claim form and a copy of the bill or receipt for each claim line in the envelope in your kit. If you do not have an envelope from your kit, send the claim to:

MassHealth, BC & R, Family Assistance C.A.R.E. Coordinator, P.O. Box 85, Essex Station, Boston, MA 02112.

Commonwealth of Massachusetts ■ Executive Office of Health and Human Services ■ Office of Medicaid